Supreme Court, U.S.
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No.

IN THE

Supreme Court of the United States

CIGNA HEALTHCARE OF TEXAS, INC., AND
CIGNA CORPORATION,

Petitioners,

v.

RUBY R. CALAD, *et al.*,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

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PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether § 502(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1132(a), completely preempts a state-law tort claim seeking damages for an allegedly erroneous determination of entitlement to a benefit under an ERISA-governed health benefit plan when the determination is based in part on the exercise of medical judgment.

PARTIES TO THE PROCEEDING

Petitioner CIGNA HealthCare of Texas, Inc., was defendant-appellee in appeal No. 01-10891 below. Respondent Ruby R. Calad was plaintiff-appellant-cross-appellee in No. 01-10891. The following individuals were parties to two other cases consolidated for argument with No. 01-10891 in the court of appeals, and are respondents to this petition: Aetna Health Inc., successor to Aetna U.S. Healthcare Inc. and Aetna U.S. Healthcare of North Texas Inc., defendants-appellees in No. 01-10905 and defendants-appellees-cross-appellants in No. 01-10891; Juan Davila, plaintiff-appellant in No. 10905; Walter Patrick Thorn, plaintiff-cross-appellee in No. 01-10891; Robert Roark and Robert Roark, on behalf of the estate of Gwen Roark, plaintiffs-appellants in No. 01-10831; Humana, Inc., Humana Health Plan of Texas, Inc., and Humana HMO Texas, Inc., defendants-appellees in No. 01-10831.

RULE 29.6 DISCLOSURE

The parent of CIGNA HealthCare of Texas, Inc., is CIGNA Corporation, a publicly-traded company.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner CIGNA HealthCare of Texas, Inc., respectfully prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case. In the alternative, petitioner respectfully requests that this petition be held pending review of the petition filed in *Aetna Health Inc. v. Davila*, No. 02-1845 (petition for cert. filed June 20, 2003) (arising out of same court of appeals opinion), or *Vytra Healthcare v. Cicio*, No. 02-___ (petition for cert. filed July 11, 2003) (not yet docketed).

OPINIONS BELOW

The opinion of the court of appeals (App. 1a) is reported at 307 F.3d 298 (5th Cir. 2002). The memorandum opinion and order of the United States District Court for the Northern District of Texas denying respondent Calad's motion to remand and dismissing the complaint with prejudice (App. 29a) is unreported.

JURISDICTION

The district court had jurisdiction over the plaintiff's claims under 28 U.S.C. § 1331 and the complete preemption effected by 29 U.S.C. § 1132. The court of appeals asserted jurisdiction over the district court's final judgment pursuant to 28 U.S.C. § 1291. The judgment of the court of appeals was entered on September 17, 2002. The court of appeals denied CIGNA's petition for rehearing en banc on April 15, 2003. This Court has jurisdiction under 28 U.S.C. § 1254(1). Because this proceeding challenges the constitutionality of a state statute under the Supremacy Clause of the Constitution, notification required by Rule 29.4(c) has been submitted to the Attorney General of Texas.

STATUTES AND CONSTITUTIONAL PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution provides: "This Constitution, and the laws which shall be made in pursuance thereof . . . shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any thing in the Constitution or laws of any State to the contrary notwithstanding." U.S. Const. art. VI, cl. 2. The pertinent provisions of ERISA, 29 U.S.C. §§ 1001 et seq., and the Texas Health Care Liability Act ("THCLA"), Tex. Civ. Prac. & Rem. Code Ann. §§ 88.001-.003, are set forth in the appendix hereto. App. 47a-67a.

STATEMENT OF THE CASE

The question in this case has squarely divided the circuits, and has placed two circuits in direct conflict with this Court, on a matter of pressing importance to employers, employees, health plans, and their participants and beneficiaries: whether a plaintiff may state a claim for damages (including punitive damages) under state law against an HMO for a decision denying health benefits under an employee health plan governed by ERISA, when the benefit determination was made by a claims-processing agent who was not the employee's treating physician. This Court held in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), that the ERISA provision creating an action for recovery of benefits was intended by Congress to the exclusive means by which an ERISA plan beneficiary could contest a benefit determination made by the plan. The Fifth Circuit in this case nevertheless held that a state is free to create new causes of action, with the compensatory and punitive damages unavailable under ERISA, through which beneficiaries may also challenge benefit determinations. The Second Circuit agrees with the Fifth, while the Third and Fourth Circuits have expressly held that ERISA preempts state law causes of action indistinguishable in substance from the action al-

lowed here. Certiorari should be granted to resolve this deep and irreconcilable split in authority.

1. Petitioner CIGNA HealthCare of Texas ("CIGNA") operates a federally qualified health maintenance organization ("HMO") which provides healthcare benefits to subscribers. CIGNA contracts with employers and others to administer benefits available under plans established pursuant to ERISA, 29 U.S.C. §§ 1001 et. seq.

Respondent Ruby Calad receives healthcare benefits through a CIGNA-administered ERISA plan provided by her husband's employer. Under the terms of Calad's employer-sponsored plan, Calad is entitled to payment only for "medically necessary" treatments or procedures. As part of its administrative duties, CIGNA therefore engages in "utilization review services," a determination of whether treatments are medically necessary and therefore covered under the plan.

According to the facts alleged in her complaint, Calad underwent a hysterectomy with rectal, bladder and vaginal repair. Calad alleges that her treating physician recommended a hospital stay of longer than a day, but that CIGNA's utilization review personnel determined that only the standard one-day stay was medically necessary and thus that Calad was not entitled under the terms of her benefit plan to reimbursement for a longer stay. Calad did not protest this benefits determination, and went home. A few days after her release, Calad alleges that she returned to the emergency room suffering complications from the surgery. Calad attributes these complications to CIGNA's determination that her plan entitled her to no more than one post operative day in the hospital.

2. Calad sued[1] CIGNA in Texas state court under the

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[1] Calad sued jointly with Walter Thorn, whose claims run solely against Aetna. Although the district court used its discretion to remand Thorn's claims to state court, it held that supplemental jurisdiction over Thorn's claims was proper based on their joinder to Calad's claims. After the Fifth

Texas Health Care Liability Act ("THCLA"), Tex. Civ. Prac. & Rem. Code §§ 88.0001-88.003. Calad asserted a negligence cause of action under the statute, alleging that CIGNA acted negligently in deciding that additional time in the hospital was not authorized for coverage because it was not medically necessary, that CIGNA had failed to use ordinary care in making its medical necessity decisions, and that CIGNA's system made substandard care more likely.

CIGNA removed the case to federal district court on December 11, 2000, asserting that Calad's claims were completely preempted by ERISA and were therefore removable based on the district court's federal question jurisdiction. Calad's motion to remand was denied. The district court concluded that Calad was effectively challenging the amount of benefits that she had received under her plan and that relief was therefore available exclusively under ERISA:

> [T]he Court concludes that Calad's claim brought under THCLA is, at bottom, not about quality of care but rather about her HMO's coverage determination and administration of her benefits. The Court therefore holds that Calad's claims against CIGNA are completely preempted and were properly removed under federal question jurisdiction.

App. 40a. Because Calad told the district court she would not amend her pleading to bring an ERISA claim should the court deny her motion to remand, the court dismissed Calad's claim under Rule 12(b)(6). App. 40a.

3. A panel of the Fifth Circuit consolidated Calad's appeal for argument with several other removed ERISA actions, including those of Juan Davila and Gwen Roark, and reversed.

Circuit held that the district court never had removal jurisdiction over Calad's claims, it noted that remand of Thorn's claims was mandatory, not discretionary. App. 21a.

App. 2a. The court of appeals recognized that federal courts have original jurisdiction, and thus removal jurisdiction, over claims brought entirely under state law only if the relevant federal statute completely displaces any state causes of action. The court observed that only some cases under ERISA, namely those that fall under ERISA § 502(a), are subject to this complete preemption rule. App. 9a. Claims that fall outside the scope of § 502(a) are not removable, even if subject to conflict preemption under the broader auspices of ERISA § 514. Narrowly interpreting what constitutes "falling within the scope" of § 502(a), the court of appeals held that § 502(a) completely preempts a state-law claim only if the claim precisely "duplicates" a cause of action available under § 502(a). It therefore reasoned that Calad's claims would only be completely preempted, and therefore removable, "if Calad . . . could have brought [her] claims under ERISA § 502(a)." App. 1a.

Rather than considering whether the *remedy* created by the THCLA improperly supplemented the exclusive remedial scheme set out in § 502(a), the standard set out by this Court in *Pilot Life*, the court proceeded to analyze whether Calad could have brought the identical claim under any of the subsections of § 502(a). The court immediately dismissed section 502(a)(3), which permits actions "by a participant, beneficiary, or fiduciary" to enjoin or obtain equitable relief to redress violations of ERISA or enforce any of the terms of the plan. The court found that § 502(a)(3) does not duplicate Calad's claim because it provides only equitable relief, not the damages available under the THCLA. *Id.* at 10a.

The court then reviewed the other enforcement provisions of § 502(a) that provide causes of action to ERISA participants and beneficiaries. The court concluded first that Calad could not bring a claim against an HMO under § 502(a)(2) after this Court's decision in *Pegram v. Herdrich*, 530 U.S. 211 (2000). Section 502(a)(2) allows a plan participant or beneficiary to sue for "appropriate relief" for a breach of fiduciary duty under

section 1109. In *Pegram*, a decision that did not involve ERISA preemption, this Court held that a plaintiff could not hold her physician-owned HMO vicariously liable for her physician's medical malpractice under § 502(a)(2), because "mixed eligibility decisions by HMO physicians are not fiduciary decisions under ERISA." 530 U.S. at 237. The Fifth Circuit acknowledged that the plaintiff in *Pegram* had claimed that her *doctor* made the erroneous medical decision, while Calad claimed her *HMO* committed medical malpractice, but the court nevertheless held that, under *Pegram*, a plaintiff can have no claim against an HMO under § 502(a)(2) for fiduciary breach, and thus that § 502(a)(2) does not provide the basis for complete preemption. App. 13a-14a.

The court next reviewed Calad's potential causes of action under § 502(a)(1)(B), which permits a plan participant or beneficiary to "enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). Because Calad could only seek reimbursement for the benefits denied her pursuant to her contract under § 502(a)(1)(B), and could not seek tort damages for medical malpractice, the court of appeals held that Calad's ERISA benefit-recovery claims do not precisely duplicate her potential state claims under the THCLA. Although the origin of CIGNA's duty to provide any services to Calad would rest entirely in her ERISA-governed plan document, the court further noted that the wording of Calad's plan document was "immaterial" for the purpose of Calad's tort claim, because Calad "invoke[d] an external, statutorily imposed duty of 'ordinary care.'" App. 17a.

After reviewing each possible cause of action open to respondent under § 502(a), the court finally considered whether the imposition of THCLA remedies impermissibly supplemented the exclusive remedial scheme of § 502(a). The court acknowledged this Court's decision in *Pilot Life* holding that "ERISA provides a means of collecting benefits and set[s] forth

an exclusive list of remedies" and that "states could not create alternative causes of action for collecting benefits that expanded upon ERISA's remedies." App. 19a. But the court declined to follow *Pilot Life* on its own terms, concluding that this Court's subsequent decisions have narrowed the broad but clear holding of *Pilot Life*. Accordingly, rather than finding the THCLA completely preempted because it effectively alters § 502(a)'s exclusive remedial scheme, the court applied its new rule that § 502(a) only preempts state-law causes of action that precisely duplicate the causes of action in § 502(a). "Because the THCLA does not provide an action for collecting benefits," the court concluded," it does not duplicate § 502(a)(1)(B) and thus "is not preempted by § 502(a)(1)(B) under *Pilot Life*." *Id.*

Having established that § 502(a) does not completely preempt Calad's claims because her THCLA claims do not exactly duplicate the causes of action available to her under ERISA, the court found that Calad's claims do not arise under federal law, as required for removal jurisdiction. The court therefore reversed the district court's denial of Calad's motion to remand and ordered the case remanded to state court for adjudication of Calad's state-law negligence claim against CIGNA.

REASONS FOR GRANTING THE WRIT

This petition seeks review of a judgment in a case consolidated in the court of appeals for argument with two other cases, one involving state-law claims against Aetna Health Inc. and the other involving state-law claims against Humana Inc. Aetna, like CIGNA, lost in the court of appeals and has already filed a petition for certiorari seeking review of the same complete preemption issue raised in this petition. *Aetna Health Inc. v. Davila*, No. 02-1845 (petition filed June 20, 2003). For the reasons stated in Aetna's petition, both petitions should be granted and consolidated for argument and decision by this Court. In the alternative, if Aetna's petition is separately granted, this petition should be held pending review and dispo-

sition of Aetna's case.[2]

We need not rehearse all the reasons certiorari should be granted to review the decision below refusing to find the state-law claims against Aetna and CIGNA completely preempted by ERISA. Those reasons are fully elaborated in Aetna's petition and are incorporated by reference here. This petition summarizes the principal reasons certiorari should be granted: the irreconcilable conflict between the decision below and this Court's decision in *Pilot Life*, and the irreconcilable conflict in the circuits over whether state-law claims such as Calad's are completely preempted by ERISA.

I. THE COURT SHOULD GRANT REVIEW BECAUSE THE FIFTH CIRCUIT'S DECISION DIRECTLY CONFLICTS WITH DECISIONS OF THIS COURT

As Aetna's petition demonstrates, the decision below directly conflicts with this Court's decision in *Pilot Life* and with subsequent decisions construing and applying *Pilot Life*. Aetna Pet. 10-19.

1. ERISA § 502(a)(1)(B) provides a civil enforcement action "to recover benefits due to [a participant or beneficiary]

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[2] A petition for certiorari presenting the same issue was also filed July 11, 2003, in *Vytra Healthcare v. Cicio*, No. 02-__ (not yet docketed). The instant petition also could be held pending review of the *Vytra* petition if it is granted. A petition was also filed on June 3, 2003 in *Roark v. Humana Inc.*, No. 02-1826, which arises out of the opinion below and presents essentially the same issue in terms of § 514 "conflict" preemption. Another petition presenting the issue as one of "conflict" preemption was filed on June 17, 2003 in *Conover v. Aetna U.S. Healthcare*, No. 02-1864. As Aetna's response to the *Roark* petition explains (Brief for Respondent Aetna U.S. Healthcare, No. 02-1826, at 3-6), the question of § 502(a) complete preemption is logically antecedent to the conflict preemption issue; thus the Court should hold *Roark* and *Conover* pending review of the petitions, including the instant petition, presenting the complete preemption issue. If the petition is granted in either *Roark* or *Conover*, of course, the instant petition should be held pending disposition of that case.

under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B). In *Pilot Life*, this Court held that § 502(a)(1)(B) "provides an exclusive federal cause of action" for a resolution of "a suit by a beneficiary to recover benefits from a covered plan." *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 62-63 (1987) (citing *Pilot Life*, 481 U.S. at 56). The federal cause is exclusive, and completely preempts any state-law claim that seeks to provide different or additional remedies for a wrongful denial of benefits. This is so, the Court explained in *Pilot Life*, because § 502(a)(1)(B) is one but one part of a "carefully balanc[ed]" scheme of remedies devised by Congress to regulate the operation of ERISA plans:

> The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA. "The six carefully integrated civil enforcement provisions found in § 502(a) . . . provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly."

Pilot Life, 481 U.S. at 54 (quoting *Mass Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146 (1985)) (emphasis in original). The Court applied that rule to hold that § 502(a)(1)(B) completely preempted a state-law breach of contract claim and a tort claim of bad faith, because allowing such claims – which would have allowed the plaintiff to recover consequential and punitive damages *not* authorized under ERISA – would have upset the careful remedial balance struck in ERISA § 502(a). *Id.* at 50, 54, 57.

The decision below plainly cannot be reconciled with *Pilot Life*. The gravamen of Calad's complaint was a challenge to a benefit determination made by CIGNA. Under *Pilot Life*, § 502(a)(1)(B) is the sole basis for bringing such a challenge.

The Fifth Circuit nevertheless allowed Calad's challenge to proceed under THCLA. The court did not deny that Calad's claim challenged a benefit determination; instead the court held that § 502(a)(1)(B)'s preemptive force applies *only* where the state-law claim "duplicates" the cause and remedy already provided under § 502(a)(1)(B) itself. Reasoning that § 502(a)(1)(B) is only tantamount to a contract action, whereas THCLA creates tort claims and tort remedies, the court held that Calad's THCLA claim did not duplicate a § 502(a)(1)(B) claim and thus was not preempted.

That conclusion not only conflicts with *Pilot Life*, it turns *Pilot Life*'s preemption analysis entirely upside down. The Court's very point was that ERISA § 502(a)(1)(B) must completely preempt state-law claims and remedies that are *different* from the specific claims and remedies that Congress decided to make available in actions challenging benefit determinations, because otherwise the state-law claims and remedies would disrupt ERISA's comprehensive and uniform system of benefit plan regulation. As the Court put it, states absolutely *cannot* provide "remedies under state law that Congress rejected in ERISA," because if they could, ERISA's own carefully calibrated remedial structure "would be completely undermined." 481 U.S. at 54. The Fifth Circuit in this case held exactly the opposite: state law claims *can* proceed whenever they seek "remedies under state law that Congress rejected in ERISA." The decision below and the decision in *Pilot Life* cannot logically coexist.

2. Aetna's petition further demonstrates the error in the court of appeals' assumption that decisions of this Court subsequent to *Pilot Life* have whittled § 502(a)(1)(B) preemption down to the "duplication" principle that is the mirror opposite of the true preemption rule articulated in *Pilot Life*. In fact, the Court's decisions have consistently reinforced the *Pilot Life* rule. Aetna Pet. 14-19 (discussing *Ingersoll-Rand Company v. McClendon*, 498 U.S. 133 (1990); *Rush Prudential HMO, Inc.*

v. Moran, 536 U.S. 355, 380 (2002); and *Beneficial Nat'l Bank v. Anderson*, 123 S. Ct. 2058 (2003)). Of the Court's decisions since *Pilot Life*, the two most important on this point clearly are *Pegram v. Herdrich*, 530 U.S. 211 (2000), and *Rush Prudential*.

a. *Pegram*, of course, was not a preemption case at all; it holds that ERISA's cause of action for fiduciary breach does not cover a "mixed" medical treatment/eligibility determination, *when such a determination is made by the participant's doctor*. 530 U.S. at 231. But the case does bear somewhat on preemption analysis. In the latter part of the opinion the Court explained that if a mixed treatment/eligibility decision, made by a beneficiary's own treating physician acting on behalf of the HMO, constitutes the act of a fiduciary under ERISA § 502(a)(2), it would unnecessarily create a federal body law of malpractice law to be applied to the decisions of HMO treating physicians. *Id.* at 235-36. More important for present purposes, it would also create a "puzzling issue of preemption," since the preemptive sweep of § 502(a) would literally make a federal case out of every such decision. *Id.* at 236. Some courts have read this discussion to suggest that a *treating* physician's mixed treatment/eligibility decisions should remain the province of state-law medical malpractice.[3]

However puzzling the preemption issue discussed but not resolved in *Pegram* may be, it is *not* the preemption problem raised here. As noted, the plaintiff's complaint in *Pegram* was against her own doctor for a decision she made, albeit while in her capacity as both the plaintiff's doctor and as an agent-

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[3] This is the holding of *Pappas v. Asbel*, 768 A.2d 1089 (Pa. 2001) and *Villazon v. Prudential Health Care Plan, Inc.*, 843 So.2d 842 (Fla. 2003). For the reasons explain in the text, those holdings are not implicated in this case, which raises only the question whether medical malpractice law or other state tort laws may be applied to a mixed treatment/eligibility decision made by an ERISA claims administrator who is *not* the plaintiff's treating physician.

owner of the HMO. Under *those* circumstances, difficult questions may well arise about the interplay between ERISA preemption and state medical malpractice regulation of a treating physician's medical decisions. But the decision being challenged here was not made by the plaintiff's treating physician, who may have an underlying state-law professional duty to the plaintiff, but by an internal HMO administrator whose only duty was to determine plaintiff's entitlement to benefits under the terms of her ERISA plan. *Pegram*'s discussion of mixed treatment/eligibility decisions simply was not addressing that situation, because that was not the situation in *Pegram*.

As the Solicitor General has explained in a brief filed with this Court: "The better reading of *Pegram* . . . is that it addresses only mixed decisions made by *treating* physicians. *Pegram* grew out of such a decision by the plaintiff's treating physician, see 530 U.S. at 215, 217, 231, and there is no indication that the plaintiff then sought review pursuant to the HMO's appeals process. Furthermore . . . the Court did appear to view her claim as involving only an attack on the compensation policies [of HMOs] as they affected treating physicians." Brief of United States as Amicus Curiae, No. 00-1021, *Rush Prudential HMO, Inc. v. Moran*, at 8. *Pegram*'s discussion of "mixed" treatment/eligibility decisions thus does not apply to, for example, the decision "of another physician who is ruling on a beneficiary's internal appeal of the denial of her claim," *id.*, even though such a physician obviously exercises medical judgments. *See also Cicio v. Does*, 321 F.3d 83, 109 (2d Cir. 2003) (Calabresi, J., dissenting) (*Pegram* discussion "only make[s] sense where the underlying negligence also plausibly constitutes medical maltreatment by a party who can be deemed to be a treating physician or such a physician's employer, as was the case in *Pegram*"). In other words, even after *Pegram*, "mixed" treatment/eligibility decisions, when they are made not by treating physicians, but by internal review physicians – or, here, by a "hospital discharge nurse" – remain

benefit determinations subject to challenge exclusively under § 502(a)(1)(B).

b. Any conceivable doubt on that score should have been erased by the Court's subsequent opinion in *Rush Prudential*. The Fifth Circuit in this case read *Rush Prudential* as narrowing the holding in *Pilot Life*. App. 19a. This, again, turns a precedent of this Court on its head.

Rush Prudential involved an ERISA-preemption challenge to a state statute requiring that HMOs establish independent review boards to review certain treatment claims. Far from narrowing *Pilot Life* to the duplication-of-remedies rule adopted by the Fifth Circuit here, the Court in *Rush Prudential* explicitly reaffirmed *Pilot Life*'s holding that ERISA preempts any state law that "add[s] to the judicial remedies provided by ERISA," because such a law would be "incompatible with ERISA's enforcement scheme." 536 U.S. at 379. The internal review board scheme at issue in *Rush Prudential* survived application of what the Court called "*Pilot Life*'s categorical preemption" rule only because the scheme "provide[d] no new cause of action under state law and authorize[d] no new form of ultimate relief." *Id.* at 379-80.

Calad's THCLA claim, by marked contrast, involves *both* a new cause of action under state law *and* a new form of ultimate relief. It is utterly impossible to square the Fifth Circuit's decision to allow such claims to go forward with this Court's application of the *Pilot Life* rule in *Rush Prudential*.

3. Certiorari is warranted to resolve the obvious and intolerable conflict between the decision below and the decisions of this Court. Only this Court has the prerogative of overruling its own decisions. *See Agostini v. Felton*, 521 U.S. 203, 258-59 (1997). Until such time as this Court holds that allowing states to supplement ERISA's claims and remedies as they see fit will not frustrate Congress's carefully calibrated enforcement scheme or its desire for a uniform national system of benefit

plan regulation, lower courts are obliged to follow the rules this Court's cases have clearly set forth. *See id.*

II. THE COURT SHOULD GRANT REVIEW TO RESOLVE A DIRECT SPLIT IN THE CIRCUITS OVER THE QUESTION PRESENTED

As Aetna's petition also elaborates, the Fifth Circuit is not alone in its departure from this Court's precedents on the question presented here. Aetna Pet. 19-28. The Second Circuit recently reached the same result, refusing to find preempted a state-law claim attacking an administrative denial of benefits. In direct conflict with the holdings of the Second and Fifth Circuit, the Fourth, Eighth, and Tenth Circuits have held that, even after *Pegram*, ERISA preempts state-law claims that are indistinguishable in substance from those allowed to proceed by the Second and Fifth Circuits. Further, decisions in numerous other circuits addressing state-law claims targeting non-medical benefit determinations have found them preempted on the basis of the categorical *Pilot Life* preemption rule rejected in this case. Because the claims in those cases did not duplicate remedies already available under § 502(a), they would have been allowed to proceed had they arisen the Fifth Circuit. Certiorari should be granted to resolve these irreconcilable circuit conflicts.

1. Like the Fifth Circuit did here, the Second Circuit recently interpreted *Pegram* as narrowing the holding in *Pilot Life*. *See Cicio v. Does*, 321 F.3d 83, 104 (2d Cir. 2003), *petition for cert. filed*, No. 02-__ (July 11, 2003). *Cicio* involved a state-law medical-malpractice challenge to an HMO's decision to approve a less expensive treatment than the one sought by the plaintiff and recommended by his treating physician. Under *Pilot Life*, such a challenge clearly would be categorically preempted because it reflects an effort to supplement ERISA's claims and remedies with new medical malpractice claims and remedies. The Second Circuit, however, declined to apply the *Pilot Life* categorical preemption rule; instead the court held,

relying almost entirely on *Pegram*, that "a state law malpractice action, if based on a 'mixed eligibility and treatment decision,' is not subject to ERISA preemption when that state law cause of action challenges an allegedly flawed medical judgment as applied to a particular patient's symptoms." 321 F.3d at 102. The court dismissed the argument that the "mixed eligibility and treatment decision" discussion in *Pegram* related only to decisions made by the plaintiff's own treating physician when he or she is also an agent-owner of the HMO. *See supra* at 6, 11-12. Even when a benefit determination is made by a "utilization review agent[]," the court concluded, it may be challenged through a state-law medical malpractice claim merely so long as it included some medical judgment (as most do, the court recognized). 321 F.3d at 104.

Judge Calabresi dissented. Although sympathetic to the majority's desire to reach a result that would enable the plaintiff to obtain damages, via state law, for injuries suffered as a result of an allegedly wrongful denial of benefits, Judge Calabresi observed: "[I]n the end I cannot reconcile the majority's holding with the Supreme Court's precedents and with the structure of ERISA itself, given those precedents." *Id.* at 106. In Judge Calabresi's view, because the action targeted a benefits determination made by a plan administrator who was not acting as the plaintiff's doctor, it was a "paradigmatic suit to remedy the violation of rights under the terms of the plan," and therefore preempted. *Id.* at 109. The fact that the allegedly erroneous benefit determination might have been made in part because of a "medical error," Judge Calabresi concluded, is "irrelevant" to the question of preemption: given that state-law claims challenging *non*-medical errors in benefit coverage determinations clearly are preempted, "there is no apparent reason, in state or federal law, for treating the unlawful coverage decision any differently from any other unlawful coverage decision that is *not* based on medical error." *Id.* at 109.

2. In contrast to the Second and Fifth Circuits, the Fourth,

Eighth and Tenth Circuits have held that state law claims against non-treating medical representatives of HMOs for their "mixed" medical/eligibility determinations are completely preempted by § 502(a).

a. In *Marks v. Watters*, 322 F.3d 316 (4th Cir. 2003), the plaintiffs brought claims against doctors, healthcare organization and insurance-related entities based on the medical decision to release an ERISA beneficiary from a psychiatric hospital to outpatient care, after which he killed his family and himself. Although the plaintiffs argued that the decision to release the patient was a mixed decision of eligibility and treatment under *Pegram*, the Fourth Circuit found that neither the beneficiary's healthcare insurer nor the case manager employed to perform utilization review services in connection with the patient's treatment was ever engaged to provide actual treatment or make treatment decisions for the patient. *Id.* at 325. Because the healthcare insurer and utilization review case manager had only been involved in the administration of the patient's claims and not the treatment of the patient, the court found the claims completely preempted under § 502. The court noted:

> The core allegation underlying a § 502(a) claim is that a plan participant or beneficiary was denied a benefit to which the participant or beneficiary was entitled under an ERISA plan or *that the manner of administering the benefits caused the participants or beneficiaries some injury*. . . . Plaintiffs cannot transform what is properly considered a § 502(a) claim into a state-law claim for malpractice simply by making unsubstantiated and incorrect statements that an independent utilization review agent was responsible for medical decisions.

Id. at 326-27 (emphasis added).

b. In *Thompson v. Gencare Health Systems, Inc.*, 202 F.3d 1072 (8th Cir. 2000) (per curiam), the Eighth Circuit described

the preemption issue raised here as "recurring" but controlled by "well-settled" law, including *Pilot Life*. *Id.* at 1073. The plaintiff in that case, like respondent Calad here, asserted a state-law claim against her HMO for negligent medical care in its determination that a certain care strategy was not medically necessary and thus was unavailable under the terms of the plaintiff's health benefit plan. *Id.* at 1073-74. "In substance," the court explained, the plaintiff "asserts a tort claim for damages on account of [the HMO's] allegedly wrongful benefits decisions as plan administrator." *Id.* at 1074. But *Pilot Life* and its Eighth Circuit progeny, the court held, "make clear" that such a claim "is completely preempted by ERISA's remedies." *Id.* Not so in the Second or Fifth Circuit, however.

c. In *Conover v. Aetna U.S. Healthcare, Inc.*, 320 F.3d 1076 (10th Cir. 2003), *petition for cert. filed*, No. 02-1864 (June 17, 2003), the Tenth Circuit reached the same result as the Fourth in *Marks* and the Eighth in *Gencare*, with respect to the same kind of claim. The plaintiff in that case brought a state-law tort claim of bad faith challenging the HMO's decision to suspend her long-term disability benefits on the basis of its judgment that she was capable of performing the material duties of her occupation. *Id.* at 1077. Directly contrary to the duplication-of-remedies preemption rule applied by the Fifth Circuit here, the Tenth Circuit held, on the basis of *Pilot Life* and *Rush Prudential*, that the plaintiff's bad faith claim was preempted precisely because it sought remedies *different* from those allowed under ERISA:

> Oklahoma's [bad faith] law allows plan participants to obtain "consequential and, in a proper case, punitive, damages" for breach of good faith and fair dealing by an insurer. . . . Nowhere does the Employee Retirement Income Security Act allow consequential or punitive damages. Damages are limited to the recovery of "benefits due . . . under the terms of the plan." *See* 29 U.S.C. § 1132(a)(1)(B). Oklahoma's bad faith law

> therefore "allows plan participants to obtain remedies . . . that Congress rejected in the Act." *Rush Prudential*, 122 S. Ct. at 2165 (quoting *Pilot Life*, 481 U.S. at 54).

320 F.3d at 1080. The reasoning and result in *Conover* are 180 degrees opposite the reasoning and result in this case.

3. In addition to these decisions involving claims attacking "mixed" treatment/eligibility decisions by HMO administrators who are not treating physicians, numerous other circuits have held that state-law claims challenging the denial or delay of benefits for non-medical, administrative reasons are also preempted. Because such claims almost by definition provide remedies additional to or different from those available under § 502(a), decisions finding such claims preempted also conflict directly with the decision below. *See, e.g., Hotz v. Blue Cross & Blue Shield*, 292 F.3d 57, 60 (1st Cir. 2002) (unfair trade practices claim seeking multiple damages and attorneys fees for delay in benefits processing preempted); *Pryzbowski v. U.S. Healthcare, Inc.*, 245 F.3d 266 (3d Cir. 2001) (tort action asserting negligence and bad faith for delay in approval of surgery held preempted); *Fink v. Dakotacare*, 324 F.3d 685, 688-89 (8th Cir. 2003) (tort and unfair trade practice claim attacking improper claim processing held preempted).

4. The number of circuit decisions directly addressing ERISA's preemptive effect on the precise type of state-law claim at issue here – i.e., malpractice, negligence, and other tort-based challenges to mixed treatment/eligibility decisions by HMO benefit claims administrators – as well as the great many more addressing related challenges to more basic claims-processing decisions, are ample testament to the importance of the issue presented in this petition. With the submission of this petition, no fewer than five petitions for certiorari raising or implicating the issue presented here will be pending at one time before this Court. *See supra* at 8 & n.2. At least one other appellate decision is also pending, *see Land v. CIGNA Health-*

Care of Florida, No. 02-15549-EE (11th Cir.), and the issue is peppering the dockets of district courts nationwide, *see* Vytra Pet. 19-20. The time is ripe for intervention by this Court to settle this controversy and restore nationwide uniformity to ERISA plan regulation.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted, or, in the alternative, the petition should be held pending review of the petition in *Aetna Health Inc. v. Davila*, or in *Vytra Healthcare v. Cicio*.

Respectfully submitted,

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